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ABSTRACT

This paper presents a dynamic perspective of some of the major issues surrounding the eating disorder of bulimia. The focus is specifically on the relationship of the bulimia nervosa syndrome to the historical dynamics of the developmental process of the individual. Three major aspects of bulimia are discussed. First, there is a discussion of physiological causes which includes psychotropic drugs, neuroanatomical disorders, hypoglycemia, and internal abnormalities. This brief review of the physiological etiology of eating disorders is considered essential to rule out the possibility of a physiological base for the undesired behavior. Second, there is a conceptual clarification of bulimia; the term bulimia nervosa is defined using the criteria set forth by Russell (1979) and Fairburn (1983). Third, an eclectic approach to treatment, including individual psychodynamic therapy, behavioral/cognitive therapy, group therapy, and family therapy, is discussed. Treatment outcome studies are reviewed in which individual approaches did not prove as effective as an integrated approach to the treatment of bulimia nervosa. Case studies are used to provide clinical material for a better understanding of the application of the object relations view. This paper concludes that where the psychopathology is more severe, a greater emphasis should be placed on a dynamic component in treatment. Ten pages of references conclude the report. (Author/NB)

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BULIMIA: A REVIEW OF THE LITERATURE WITH AN EMPHASIS ON TREATMENT AND THE DYNAMIC PERSPECTIVE

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Doctoral Research Paper for the
Degree of Doctor of Psychology

ROSEMEAD SCHOOL OF PSYCHOLOGY

BIOLA UNIVERSITY

CHARLES EDWARD COULL

1986

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BULIMIA: A REVIEW OF THE LITERATURE WITH AN EMPHASIS ON TREATMENT AND THE DYNAMIC PERSPECTIVE

BY

CHARLES EDWARD COULL

A doctoral research paper submitted to
Rosemead School of Psychology
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La Mirada, California

1986

BULIMIA: A REVIEW OF THE LITERATURE
WITH AN EMPHASIS ON TREATMENT
AND THE DYNAMIC PERSPECTIVE

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Papa

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ABSTRACT

Three major aspects in the understanding and treatment of bulimia are discussed. First, there is a discussion of physiological causes which includes psychotropic drugs, neuroanatomical disorders, hypoglycemia, and internal abnormalities. Second, the term bulimia nervosa is defined using the criteria set forth by Russell (1979) and Fairburn (1983). Third, an eclectic approach to treatment, including individual psychodynamic therapy, behavioral/cognitive therapy, group therapy and family therapy, is discussed. The writer concludes that where the psychopathology is more severe, a greater emphasis should be placed on a dynamic component in treatment.

Bulimia: A Review of the Literature with an Emphasis on Treatment and the Dynamic Perspective

Eating disorders, along with substance abuse, have become popularized disorders. Many individuals are seeking and obtaining professional help as a result of this popularization. A more negative trend is the development of misconceptions and even grossly inaccurate information being publicized under the guise of helping individuals change. The purpose of this paper is to present a dynamic perspective of some of the major issues surrounding bulimia. The contents of this paper will focus specifically on the relationship of the "bulimia nervosa" syndrome to the historical dynamics of the developmental process of the individual. There will be a discussion of three aspects of bulimia.

First will be a brief review of the physiological etiology of eating disorders. This brief review is essential to rule out the possibility of a physiological base for the undesired behavior.

Second will be a conceptual clarification of bulimia. The literature reveals a major controversy about the definition of bulimia. Bruch stated that she has grave doubts that bulimia is a clinical entity (Garner & Garfinkel, 1985, p. 12). Other authors have

been more accepting of the bulimic disorder as a separate entity, but suggest further definition. Terms such as "bulimarexia" (Boskind-Lodahl & Sirlin, 1977), "bulimia nervosa" (Russell, 1979), and the "dietary chaos syndrome" (Palmer, 1979), have been introduced to help discriminate among the various levels of severity concerning this disorder.

Third will be a discussion of the dynamics of what will be referred to as bulimia nervosa. Here we will explore some object relations views of bulimia nervosa. From this perspective, it is proposed that classical psychotherapy or analysis is an important component in the treatment of certain bulimics. After an understanding of the physiological issues and a clear definition of bulimia nervosa, the reader will be able to differentiate the type of bulimic client which benefits most from an emphasis on dynamic, insight-oriented psychotherapy. This is the client that is diagnosed as having bulimia nervosa, based on an underlying pathology.

Ruling Out Physiological Etiology

The first step of evaluating an eating disorder is a medical referral for a complete physiological evaluation to rule out biological problems. A physician

who is familiar with and sensitive to eating-disorder issues should give a physical examination, perform a laboratory evaluation and do a complete medical history, including medication being used.

The need for this evaluation is emphasized by the fact that there are several physiological factors that may influence the development of an eating disorder. Some of those that influence the binge/purge behavior of bulimia are 1) psychotropic drugs, including phenothiazine and tricyclic antidepressants; 2) neuroanatomical disorders, including the epileptode phenomenon and the hypothalamus; 3) hypoglycemia; and 4) abnormalities of internal organ functions. Some of the psychotropic drugs seem to encourage an increase in appetite and thus intensify binge episodes. However, the major portion of the research has focused on the epileptode phenomenon, the hypothalamus and hypoglycemia (Loro & Orleans, 1981, p. 159; Rudnick, 1984).

The epileptode phenomenon is a state in which there is an impulsive and unplanned binge, with patients sometimes reporting an aura before the bulimic behavior. There is a state of confusion during the bulimic episode and a significant confusional state or amnesia after the episode. This is a rare occurrence in bulimics even

though there may be EEG abnormalities in a number of these patients. This phenomenon is the only cause of bulimia that has a specific treatment, which is the administering of anticonvulsant medication. The effectiveness of this has been argued, and there is significant debate concerning long-term effectiveness (Mitchell & Pyle, 1982; Pope & Hudson, 1985; Rudnick, 1984).

Therefore, the epileptode phenomenon should be seen as a specific neurological disorder occurring within the general population of people showing abnormal EEG's. It should not be assumed that the phenomenon is always present when the bulimic has an EEG abnormality. Green and Rau (1974) and Wermuth, Davis, Holester and Stunkard (1977) did studies with a group of bulimics having general EEG abnormalities. They improved markedly after being treated with phenytoin (Dilantin). In the Green and Rau study, however, a more methodologically sound study by Wermouth et al. did not support these findings. There has been little emphasis on the use of anticonvulsants in treating bulimics having general EEG abnormalities since the Wermouth et al. study.

The possible effect of hypoglycemia was shown in a well-designed study by Geiselman and Novin (1982). This

study revealed a connection between insulin-induced hypoglycemia and an increase in hunger for more carbohydrates, especially sugar. They concluded:

1. Appetite and hunger may be direct functions of dietary carbohydrate, especially sugar, content.

2. We have attributed the appetite- and hunger-producing effects of carbohydrates to insulin-induced hypoglycemia.

3. Just as postabsorptive insulin-induced hypoglycemia can stimulate hunger after a high-carbohydrate meal, preabsorptive insulin-induced hypoglycemia probably explains how the anticipation, sight, smell or taste of palatable high-carbohydrate foods can stimulate appetite.

4. Rather than increasing appetite and hunger in general, insulin-induced hypoglycemia may specifically increase appetite and hunger for carbohydrates, especially sugars. If carbohydrate-induced cues and carbohydrate ingestion with their hormonal and metabolic sequelae (including preabsorptive and postaborptive insulin-induced hypoglycemia) result in ingestion of more carbohydrates (specifically sugars), then one can

> easily envision that a vicious cycle might ensue and ultimately may lead to exhaustion of the pancreatic Beta cells.
>
> 5. All carbohydrates are probably not equally important in the prevention and treatment of obesity. Diets high in simple-sugar content may produce greater appetite and hunger than high-starch diets. . . .
>
> 6. In addition to causing obesity by increasing appetite and hunger, high-carbohydrate diets may also perpetuate the obese condition by maintaining hyperinsulinemia and the consequent hypoglycemia and hyperphagia. (p. 216)

The medical condition of hypoglycemia and diets high in sugar content clearly mimic the binge behavior of the bulimic. Geiselman and Novin (1982) clearly show the dramatic impact of insulin-induced hypoglycemia on eating patterns. This further emphasizes the importance of evaluating the biological functioning of the bulimic and consideration of the possible cycling of binges due to a high-carbohydrate diet, especially sugar content.

Research on the hypothalamus has focused on the ventral medial hypothalamus--the control center--and the lateral hypothalamus--the appetite center. In the

past, it has been shown that a lesion in the ventral medial hypothalamus will result in uncontrolled eating, while a lesion in the lateral hypothalamus results in starvation. More recent research has shifted away from the hypothalamus and now emphasizes a more global view of bodily functions in explaining abnormal eating behaviors. This includes the entire internal organ system, glucose level, hormones, enzymes, and neurotransmitters (Copeland, 1985; Rudnick, 1984). It is beyond the scope of this paper to discuss all of these aspects of physiological research concerning bulimia. If the reader is interested in further information, he or she is referred to Copeland (1985).

The importance of a physiological understanding and evaluation of bulimic behavior can also be seen in the severity of the physiological effects of this behavior. They include (a) gastric ruptures of the stomach, the esophagus, and the intestinal tract; (b) acute gastric dilatations; (c) renal failure; (d) parotid gland swelling (moon face); (e) abnormal electrolytes; (f) urinary tract infection; (g) ulcers of the mouth and tongue; and (h) dental problems (Mitchell & Pyle, 1982, p. 68).

One of the most common and most dangerous of these effects is abnormal electrolytes. Electrolytes are those chemicals in the body that are kept in delicate balance to maintain the proper functioning of the body systems. Through the continued binging and purging by diuretics, self-induced vomiting and/or cathartics, the patient throws off vital body fluid and electrolytes, sometimes with potentially dangerous results. For example, the loss of potassium can result in arrhythmias and heart failure, which is not uncommon in bulimics.

Spack (1985) reviewed the literature concerning the medical complications of both anorexia and bulimia. He discussed biochemical effects; gastrointestinal complications; cardiovascular complications; hematologic and immunologic complications; psychologic, neurologic, and ophthalmologic complications; and dental complications. The reader is also referred to Table 1, which is a reproduction of an updated pamphlet from the National Association of Anorexia Nervosa and Associated Disorders. The table summarizes some of the physical problems resulting from eating disorders.

One other major focus has been on the use of anti-depressants. The Dexamethasone Suppression Test (DST) has been used in research to evaluate the connection

Table 1

Partial Listing of Physical Problems Brought About by Eating Disorders

	EXTERNAL PROBLEMS	INTERNAL PROBLEMS	CAUSE
SKIN	Dryness	Dehydration	Reduced fluid intake. Excessive fluid elimination.
	Fine rash		Frequent vomiting.
	Pimples		Laxative abuse.
SALIVARY GLANDS	Swelling Pain Tenderness	Puss. Infection, but usually not.	Frequent vomiting.
CONSTIPATION		Insufficient material. Insufficient fluid.	Failure to take in or retain sufficient food and fluid.
		Dulled intestinal nerves.	Laxative abuse.
EDEMA (water retention)	Swelling and puffiness more frequently ankles and feet.	Electrolyte imbalance. Perhaps general systems problems.	Malnutrition. Frequent vomiting. Excessive laxatives or diuretics.
BLOATING	Swelling over stomach or abdominal area.	Electrolyte imbalance? Time required for body systems to adjust? Insufficient protein intake.	Long periods of starvation and probable excessive vomiting, laxatives or diuretics.

Table 1 (Cont'd)

	EXTERNAL PROBLEMS	INTERNAL PROBLEMS	CAUSE
ABDOMINAL PAIN		Peptides? Hunger pangs? Changes in the bowel.	Failure to identify hunger? Emotional attitudes? Insufficient intake.
FEELING OF FULLNESS	Slight distention after eating is normal.	Normal feeling after eating for everybody.	Fear? Emotional attitudes.
TEETH	Frequent caries plus erosion of enamel.		Inadequate diet. Frequent vomiting or regurgitation. Diet limited to citrus fruits, abnormal carbohydrate intake.
AMENHORRHEA	No menstrual period.	Inability to produce hormones.	Lack of body fat, rigorous athletic training, emotional attitudes, sometimes gorging/purging.

between affective disorders, such as depression, and eating disorders. This is in response to a significant number of bulimics being diagnosed as suffering from affective disorders. The DST is a process by which the level of cortisol in the blood is measured after the introduction of dexamethasone into the patient's blood stream (Hudson, Lafter, & Pope, 1982). The test is based on research that shows abnormal cortisol levels after the introduction of dexamethasone for patients who are diagnosed as being chronically depressed.

Pope and Hudson (1985) reviewed the literature concerning the treatment of bulimia with anti-depressants. Most of their discussion centered on research with imipramine (Pope, Hudson, Jonas, & Yurgelun-Todd, 1983), and mainserin (Sabine, Yonace, Farrington, Barratt, & Wakeling, 1983). These two antidepressants showed contradictory results, with imipramine being more favorable. Pope and Hudson (1985) concluded:

> This study provides persuasive evidence that antidepressants are rapidly effective in many cases of bulimia and indirect evidence for the hypothesis that bulimia is related to major affective disorders. Of course, we would emphasize that the

> results are hardly spectacular. Although 90% of subjects improved, only about one third of subjects experienced an essentially complete remission of their bulimic behavior. On the other hand, it should be recalled that these subjects had chronic cases of bulimia, refractory to multiple previous therapeutic attempts over years of time. Therefore, even a 35% rate of remission, over the space of two weeks, is gratifying in such a severely ill population. (p. 84)

These results indicate that there is some indication of a positive reaction to the use of antidepressants with bulimics. However, it must be kept in mind that no single approach to the treatment of bulimia has shown marked results for all bulimics. This lends support to the possibility that a certain portion of the bulimic population may respond best to an emphasis on dynamic, insight-oriented psychotherapy approach.

This section has pointed out various possible physiological causes of bulimic behavior. When a clear medical cause for the bulimic behavior cannot be found, then psychological causes need to be considered. It may be that bulimic behavior indicates a deeper, underlying

psychological pathology. Before considering this possibility, however, there needs to be a conceptual clarification of bulimia to distinguish bulimic behavior as an indication of underlying pathology from other types of bulimic behavior patterns.

Conceptual Clarification of Bulimia

Not all those who binge and purge have an underlying pathological character structure (Rizzuto, 1985, p. 197). In Wardle and Beinart's (1981) article, they discuss the mass of confusion concerning the classification of the bulimic and present the idea of the "bulimic syndrome." It seems the term bulimia is greatly misused, even among professionals. The term bulimia is used to describe binge eating behavior in patients with anorexia nervosa (Casper, Eckert, Halmi, Goldberg & Davis, 1980), as an eating pattern in individuals who are overweight (Wilson, 1976) and as the name of a syndrome, usually seen in normal-weight individuals who frequently vomit as part of the eating problem (Pyle, Mitchell & Eckert, 1981). Mitchell and Pyle suggest that the term bulimia be used to refer to the symptom of binge eating and that the DSM III category of bulimia be referred to as the bulimic syndrome (Mitchell & Pyle, 1982, p. 70).

Fairburn (1983) discusses the use of the terms "bulimia" and "bulimia nervosa."

> The terms "bulimia" and "bulimia nervosa" have gained greatest acceptance, the former in the United States and the latter in Britain. "Bulimia" is the less satisfactory of the two terms since it encourages the use of the word "bulimia" to denote both a pattern of behavior (binge-eating) and a specific psychiatric syndrome. Instead, the term "bulimia nervosa" is preferable since it emphasizes that people with this eating disorder not only eat in binges but also exhibit other characteristic psychopathological features. Clinical experience suggests that bulimia nervosa is a subtype of bulimia in which binge-eating is accompanied by self-induced vomiting or purgative abuse and abnormal attitudes toward body weight and shape. In practice, virtually all patients who meet diagnostic criteria for bulimia nervosa also fulfill the criteria for the syndrome bulimia, although the converse is not the case. (p. 953)

For the purpose of this paper, the terms bulimia and bulimia nervosa will be used as defined above. The DSM III definition must be expanded to fit this view of

bulimia nervosa (Yates, 1984). In order for a person to be diagnosed as bulimic under DSM III (1980), they must meet the following criteria:

A. Recurrent episodes of binge eating (rapid consumption of a large amount of food in a discrete period of time, usually less than two hours).

B. At least three of the following:

1. consumption of high-caloric, easily ingested food during a binge
2. inconspicuous eating during a binge
3. termination of such eating episodes by abdominal pain, sleep, social interruption or self-induced vomiting
4. repeated attempts to lose weight by severely restrictive diets, self-induced vomiting, or use of cathartics or diuretics
5. frequent weight fluctuations greater than ten pounds due to alternating binges and fasts

C. Awareness that the eating pattern is abnormal and fear of not being able to stop eating voluntarily

D. Depressed mood and self-deprecating thoughts following eating binges.

E. The bulimic episodes are not due to anorexia nervosa or any known physical disorder. (p. 71)

In gaining an understanding of bulimia nervosa it is important to emphasize items C and D above: Item C is the "awareness that the eating pattern is abnormal and fear of not being able to stop eating voluntarily." This awareness is not just that the behavior bends the rules and anxiety that the client's eating may be slightly excessive at times, but a feeling of pathology and panic that they are incapable of controlling their behavior. Item D states, "Depressed mood and self-deprecating thoughts following eating binges." This is not a momentary guilt, but a pathological, psychologically self-destructive torment for the sufferer of bulimia nervosa.

Fairburn (1983) sets forth two tables to describe the DSM III syndrome of bulimia and the "bulimia nervosa" syndrome. Fairburn's first table lists the criteria set forth in the DSM III and is stated above. His second table adds three further criteria for the diagnosis of the syndrome "bulimia nervosa." They are:

The patients suffer from powerful and intractable urges to overeat, they seek to avoid the "fattening" effects of food by inducing vomiting or

abusing purgatives or both, and they have a morbid fear of becoming fat. (p. 954)

These three elements emphasize the emotional dynamics of the behaviors referred to in the DSM III criteria. They are also required to be present if the term bulimia nervosa is to be used, according to Fairburn. The term bulimia nervosa as defined by meeting both Fairburn's (1983) criteria and the DSM III criteria will be used in this paper.

The therapist who is attempting to make a working diagnosis of the bulimic patient must be sensitive to differentiating the symptomology from underlying pathology. Eight of the symptoms listed by Loro and Orleans (1981) are:

1. Anxiety related to external stress and deficient coping skills.

2. Interpersonal conflicts related to deficient assertion and interpersonal problem solving skills.

3. Irrational thinking, cognitive distortions and self-critical thinking leading to negative feeling states.

4. Obsession and preoccupations with thoughts of food.

5. Frustration and disappointment due to unrealistic weight loss goals and expectations.

6. Boredom resulting from unstructured time.

7. High access to privacy and preferred binge settings.

8. Hunger due to excessive dieting and strenuous exercising. (p 161)

These antecedents listed above can be applied to either the DSM III bulimic or bulimia nervosa. Thus, the client being diagnosed as bulimic without differentiating the level of pathology will present a confusing picture in response to therapy. There will also be confusion as to contributing dynamics. If the therapist has determined that a dynamic component should be emphasized in treatment, then the bulimia nervosa syndrome is likely to be seen as the manifestation of long-standing developmental voids, traumas or overnurturance. This has resulted in the need for food to satisfy the drive for internalization and incorporation rather than the desire for food merely to satisfy a momentary anxiety that is more acute or situational. The need is understood in Fairburn's (1983) statement, "The patients suffer from powerful and intractable urges to overeat." Therefore, while the

symptomology can be applied to either the DSM III bulimic or bulimia nervosa, the underlying personality structure leading to these symptoms can be significantly different.

To this point we have seen that in some cases bulimic behavior has a physiological basis and that in other cases bulimic behavior is a symptom of acting-out behavior. If these two possibilities are ruled out and the criteria for bulimia nervosa are met, then the bulimic behaviors are most likely symptoms of an underlying psychopathology which must be dealt with directly in order to help the client in more than a superficial way. To focus on this psychological approach, the next section discusses the underlying dynamics of bulimia nervosa.

Treatment and the Dynamic Perspective

> Fatness, not sex, is a taboo
> in our culture, and fatness
> has taken on evil overtones.
> (Woodman, 1980, pp. 103-104)

The object relations view of bulimia nervosa explains the binge/purge behavior as an expression of the "good" object/"bad" object split. This split is an internal differentiation resulting from inadequate

parenting and thus a failure to develop an integrated view of the self. The "evil overtones" of fatness in our culture provide a fertile ground for the projection of the "bad" self onto fatness. The binge is an attempt to take in the "good" object, and the purge is the attempt to expel the "bad" object. In this section, there will be further expansion and discussion of the statements made above.

Before formulating an object relations view of bulimia nervosa, a review of current clinical approaches to the treatment of bulimia is appropriate. Individual psychodynamic therapy is only a part of what is being considered the treatment of choice in the general population of bulimics. It is widely accepted that the most clinically productive treatment approach to the general population of bulimics is an integrative therapy approach that includes individual psychodynamic therapy, behavioral/cognitive therapy, group therapy, and family therapy (Fairburn, 1983; Lacey, 1983; Lee-Brenner, 1984; Sommers, 1983; Swift, 1983; Strober, 1984; Wardle, 1980; Wardle & Beinart, 1981; Wilson, 1983; and Yates, 1984). It is the belief of this writer that the more severe the pathology, the greater the need for individual psychodynamic therapy. However, the research has

focused more on behavioral and cognitive approaches and warrants a brief review.

Treatment Outcome Studies

The behavioral treatment approaches focus on overcoming anxiety, stress and stress-management deficits, improving assertiveness, or reducing negative feelings and self-critical thinking that can precipitate binge eating (Loro & Orleans, 1981). The behavioral approaches include training for anxiety management (Suinn, 1977), progressive muscle relaxation (Goldfried & Davison, 1976), assertiveness and interpersonal problem solving (Bower & Bower, 1976), marital conflict resolution (Weiss, Hops & Patterson, 1973), thought stopping (Cautella, 1969), and delay therapy (Meyer, 1973).

Using a pure behavioral approach to treating bulimia has not shown impressive results. In a study by Fairburn (1981), only a behavioral approach was used. A twelve-month follow-up on six out of eleven patients found two had ceased to overeat and vomit, while the other four continued to binge and purge every two or three months. At the conclusion of the study, one of the eleven patients failed to show any improvement from the treatment. This patient had the longest history of

bulimic behavior, giving a self-reporting vomiting up to thirty times a day for thirteen years.

There are no studies on the use of cognitive therapy alone in treating bulimia. However, Fairburn (1983) did outline a cognitive behavior therapy treatment procedure for bulimia. Three stages of treatment were distinguished. Stage one includes (a) self-monitoring of the food they eat as well as where and when it is eaten; (b) the prescription of an eating pattern where patients are asked to restrict their eating to three or four planned meals each day, plus one or two snacks; (c) the use of stimulus control techniques to help patients adhere to the predetermined eating plan; (d) alternative behavior plans; (e) advice regarding purgative or diuretic abuse; (f) advice regarding weighing; (g) the provision of information on weight and physical complications; and (h) joint interviews with family and friends. Stage two includes (a) the introduction of avoided foods; (b) training in problem solving; and (c) cognitive restructuring concerning abnormal attitudes toward body shape and weight, as well as toward food and eating. Stage three consists of maintenance interviews.

This cognitive behavioral program is the frame for most popular diet center programs. Not knowing how many bulimics actually benefit from this program prevents any direct conclusions from the large number of bulimics who have completed one or more of these programs and are seeking further help. Yet, it can be said that there are a large number of bulimics who do not benefit from this type of program.

Lazerson (1984) presented positive results in a group approach with five bulimic women. Minuchin, Rosman and Baker (1978) also showed effective changes in their use of family therapy with eating disorders. However, the studies did not clearly define the theory base used in either the group or family therapy approaches. These therapy techniques may best be described as eclectic in having a more generalized approach. This adds support to other integrative studies that show positive results in treating the bulimic patient.

Strober (1984) presented four necessary components of an effective treatment approach to treating bulimics. The first component is rapport. The patient must feel the therapist is learned, sensitive, compassionate, and active without smothering and that the therapist has a

grasp of what is happening psychologically and biologically. Second is the implementing of cognitive/behavioral techniques. These techniques should include developing a reasonable diet, increasing self-monitoring of eating, and increasing behaviors that are self-controlling. Third is the use of interpersonal insight-oriented therapy. Fourth is the use of group therapy for adults and family therapy for adolescents. These four components are most commonly used in the treatment of bulimics, in some combination of two or more.

In one of the long-term outcome studies, Lacy (1983) gave highly positive results from his treatment study. This treatment program included a behavioral contract concerning the eating behavior, group therapy one day a week, and insight-oriented psychotherapy. The program was designed to last ten consecutive weeks. Out of a group of 30 women,

> all the women had fewer symptoms, 24 stopped binge eating and vomiting at the end of treatment, and a further four stopped shortly afterwards. During formal follow-up 20 showed no dietary abuse and a further eight reduced their attacks to an average

of three episodes a year; all judged treatment to be a success. (p. 1)

White (1984) also supported the use of integrative approaches using individual and family therapy. This was a case study where the goal of individual therapy was to "facilitate separation and individuation" and the goal of family therapy was to "strengthen boundaries and improve transaction patterns." The integrative approach to treating bulimia nervosa has proven to be the most successful technique. Also, the treatment approaches which have included a dynamic component have been shown to be more successful (Lazerson, 1984; Minuchin et al., 1978; White, 1984) than the strictly cognitive/behavioral approach (Fairburn, 1981). In fact, there was a dynamic component to all of the treatments empirically supported by a methodologically sound outcome study (Lazerson, 1984; Minuchin et al., 1978), and the one methodologically sound outcome study that did not incorporate a dynamic component (Fairburn, 1981) was least effective. This suggests that the dynamic-oriented component of treatment is crucial in the treatment of bulimia nervosa. There may also be a need to emphasize the dynamic approach when the bulimia nervosa is more severe.

The opinion that dynamically oriented therapy is an essential component in the treatment of bulimia nervosa is consistent with psychodynamic theories, has not been proven by direct empirical studies. A better demonstration would require either studies on a treatment that was exclusively dynamic in orientation, or either a dismantling treatment strategy or a constructive treatment strategy to demonstrate that the dynamic component of eclectic treatment packages is crucial to their success (Kazdin, 1980). In a computer search of Psyc Info and Psych Abstracts from January of 1975 through December of 1985, there were no articles that reported any empirical assessment of the effectiveness of dynamically oriented therapy for bulimia nervosa. If such empirical studies were designed, it is felt that individual psychodynamic therapy alone would show no better results than behavioral or cognitive therapy alone. However, the greater the degree of pathology, the more emphasis needs to be placed on a psychodynamic component to therapy.

When we limit our discussion only to a dynamic understanding and treatment of bulimia nervosa, the research is limited to case studies and a few indirectly relevant empirical approaches, with no treatment outcome

studies. Further, available empirical research has methodological problems. In a review of the literature, Fairburn (1983) pointed out three common methodological problems in relevant studies. First, "they have been composed of university or college students, despite the fact that there is evidence that the majority of those with bulimia nervosa are not students" (p. 944). Second, "all the prevalence data have been derived from self-report measures. . .the questionnaires constructed for specific studies were not adequately assessed with regard to their reliability or validity" (p. 944). Third, "all the community studies to date have been cross-sectional in design, and few have provided information on the duration of key psychopathological features" (p. 944).

Having an understanding of the limits of methodologically sound studies concerning bulimia nervosa, the remainder of this paper will focus on the view of bulimia nervosa as understood from psychodynamic therapy and case studies, with some blending of applicable empirical studies. The main purpose of this section of the paper is to propose a theoretical approach to dealing with the more pathologically disturbed bulimic patients.

Bulimia Nervosa: A Spectrum Disorder

What is now being discovered is that the underlying conflicts and personality structure differ widely from case to case in bulimia nervosa and other eating disorders. Again, this has made it difficult for empirical analysis to identify irregularities, partly because the crucial variables are not clearly defined and are highly individualized. The issue of individuality is emphasized further in that the responsiveness to treatment seems to be related to the type of defenses that prevail in the character structure. If schizoid withdrawal and secretiveness prevail, the treatment may be very difficult. If obsessive defenses are the most prevalent, the treatment is less difficult (Rizzuto, 1985, p. 210). This information reveals the need for an even finer differentiation of bulimia nervosa in order to design appropriate treatment strategies.

Swift (1983) proposed a conceptual model for understanding the diverse clinical features of patients presenting with anorexia nervosa. He suggests that anorexia nervosa is a "spectrum disorder;" that is, it exists in varying degrees of severity in the general

population. They spoke of the "classical anorexics," stating:

> With this notion of an anorexic continuum as a starting hypothesis, we then proposed a more fine-grained classification of three psychodynamic subtypes of anorexics within the latter severely disturbed group. Proceeding from more to less disturbed patients, we described: (1) the borderline; (2) the empty, understructured; and (3) the emotionally conflicted, identity-confused anorexic. These were suggested less as distinct categories than as points on a developmental continuum. In agreement with traditional theorists we believe that all seriously disturbed anorexics suffer from problems of separation-individuation (e.g., Bruch, 1973; Masterson, 1977), and that these problems parallel problems of separation-individuation in the families (e.g., Minuchin et al., 1975, 1978; Stern et al., 1981). However, our experience indicates that both families and individual anorexics vary in the severity of deficit in this domain, with the borderline group being the least individuated and the emotionally

conflicted identity-confused group being the most. (Swift & Stern, 1983, p. 32)

The three psychodynamic subtypes mentioned by Swift can be easily applied to bulimia nervosa. Bulimia nervosa can also be described as a "spectrum disorder," compatible to the classification outlined by Swift. We have defined the syndrome of bulimia nervosa and now can see that this syndrome has varying degrees of pathology.

Clinical evidence supporting the various degrees of pathology can be found in Wilson's (1976) study. A chi square analysis was performed in his study of obesity, and a highly significant association was found between the severity (frequency) of binge eating and the age of obesity onset. Clients with early onset of obesity (childhood or adolescence) report more severe problems with binge eating than clients with adult onset of obesity.

The relationship of early onset and severity of problems adds some support to Russell's (1979) findings on premorbid personality dynamics of the bulimic patient. This study was a prospective study of 30 patients which fit the criteria for bulimia nervosa later formally defined by Fairburn (1983). A clinical assessment of the premorbid personality based on

informants' reports found only eight of the 30 patients to be "normal."

> The following abnormal traits appeared to occur with relative frequency: anxiety, especially in social relationships or with school work (8 patients); depression (4 patients); difficult personal relationships with parents or at school (9 patients); marked dependence on parents (4 patients); antisocial behavior such as abusing drugs, stealing or promiscuity (4 patients). There was no regularity in the way these abnormal traits were clustered, so that no characteristic type of personality could be said to have preceded the illness. (p. 442)

This study is the strongest link between Fairburn's definition of bulimia nervosa and the presence of preexisting abnormal personality traits which may lead to the bulimia nervosa syndrome. These two studies raise questions as to the effectiveness of treatment programs which fail to address psychodynamic aspects of the therapy process, in that "overeating could at times be interpreted as meeting an unfulfilled emotional need" (Russell, 1979, p. 443).

The association between severity and early onset fits a psychodynamic perspective that early developmental trauma results in later pathological issues acted out through eating behavior in the more severe cases of bulimia nervosa. Wilson's (1976) findings that such a large percentage of patients with severe binge-eating problems sought professional help to control their eating behavior provides some support for the clinical observation that patients who manifest binge eating may require more intensive treatment than standard behavioral programs. Treatment emphasizing a dynamic perspective may be most appropriate when the severe pathology of the individual prevents appropriate responses to less-intensive therapy techniques.

A Psychodynamic Perspective of Bulimia Nervosa

The dynamic perspective has given significant aid to the treatment of bulimia nervosa through its understanding of personality dynamics and their relation to the bulimic behavior. Bulimia nervosa has been explored by various psychodynamic writers. Cameron (1985) discusses bulimia as a "conversion reaction." Fenichel (1972) discusses eating disorders in terms of oral, anal and/or genital disturbances. Bruch (1973) has offered useful insight as to the relation of food to

personality disorders and states that the food becomes the "symbolization of the underlying conflicts." Bruch's statement summarizes the prevailing theme in the dynamic approach to the treatment of eating disorders. It is thought that once the pathological motivations to eat are removed, biologically normal eating will ensue, and weight will stabilize at an acceptable level. Bruch's statement of the "symbolization of the underlying conflicts" will be the foundation of our attempt to understand bulimia nervosa.

In attempting to understand the dynamics of the eating-disorder patient, we find that Freud and the early theorists laid the groundwork for a dynamic conceptualization of the eating-disorder personality. In the development of the earliest decisions about what is "me" and what is "not me," Freud (1925) stated:

> The function of judgement is concerned in the main with two sorts of decisions. It affirms or disaffirms the possession by a thing of a particular attribute; and it asserts or disputes that a presentation has an existence in reality. The attribute to be decided about may originally have been good or bad, useful or harmful. Expressed in the language of the oldest--the oral--

> instinctual impulses, the judgement is: "I should like to eat this," or "I should like to spit it out"; and, put more generally: "I should like to take this into myself and to keep that out." That is to say: "It shall be inside me" or "it shall be outside me." (p. 237)

Later, Anna Freud (1946) discussed the representational significance of food in the mother-child interaction: "The image of food and the mother-image remain merged into one until the child is weaned from the breast" (p. 125).

This bond is dramatically illustrated by a case discussed by Kreisler, Fain and Soule (1974):

> Christopher H. was six-and-a-half months old when he developed acute vomiting which required hospitalization after he had lost 1500 grams. The child continued to vomit after hospitalization until it was discovered that he provoked his own vomiting by means of introducing his fingers into his mouth or by a direct effort to vomit. Intensive nursing care and restriction of the hands, plus some antiemetics, brought the child back to health. Careful questioning of the mother revealed that the child was perfectly normal until

> the mother, who was an apprehensive woman, had distanced herself from the baby and had worn a facial mask for eight days because she was afraid of giving the child a cold. (p. 201)

Fain, in discussing the case, proposed a dynamic view of this, stating that the facial mask partially transformed the mother into a stranger, with the end result that the infant confused the good mother with the strange masked mother and experienced simultaneously the wish for closeness and the need to escape the frightening mother. In concluding his comments, Fain remarked that, at that age, food becomes confused with the mother and that in the case of this particular infant there must have been a need not to see the stranger's face, to repress it. Nonetheless, the child cannot ignore the awareness of the percept. At this point the problem becomes an internal psychic struggle (Rizzuto, 1985, p. 201).

The mother-child relationship of the bulimic client was most clearly set forth in Goodsitt (1983). Goodsitt introduced the theory that the eating disorder was based on a "deficient self-regulation." Much of the symptomology such as starvation, binging, vomiting, and hyperactivity is better understood as desperate measures

to drown out states of overstimulation and/or fragmentation (Goodsitt, 1983, p. 51).

Most of the theories concerning eating disorders feel the crucial developmental period of separation-individuation, as described by Mahler, Pine and Bergman (1975) (Goodsitt, 1983; Hogan, 1983; Maloney & Klykylo, 1984; Rizzuto, 1985; Sugarman & Kurash, 1982; Swift, 1985; White, 1984), is the stage where trauma occurs which results in the eating disorder. Sugarman, Quinlan and Devenis (1981) further defined the separation-individuation issue to the transition from the differentiation to the practicing subphase. They feel that the developmental process goes awry in the bulimic at that subphase. Clinical evidence (Minuchin, Rasman & Baker, 1978; Soars, 1974) suggests that a variety of intrafamilial dynamics, including violations of transactional boundaries and parental under- to over-involvement, result in the inhibition of the normal strivings for autonomy and activity associated with the practicing subphase. Food is not the issue; rather, it is the bodily action of eating which is essential in regaining a fleeting experience of mother (Sugarman & Kurash, 1982, pp. 60-61).

It has already been noted that most of the literature points to the separation-individuation phase as the time frame for traumas that result in the eating-disorder behavior. The food is seen as an object outside and separate from the self which provides some gratification. This ability to reach outside of the self does not occur until the differentiation subphase (four months to twelve months) of the separation-individuation phase. At eighteen months the child has moved through the practicing subphase and into rapprochement. The rapprochement subphase leads to a sense of object constancy, which is not believed to have been achieved in the bulimic (Mahler, Pine & Bergman, 1975).

Therefore, the subphase issues most consistent with the symbolism of the binge/purge behavior occur during differentiation and practicing (four months through eighteen months). Winnicott (1953) adds further support to this time frame when he notes a time interval between the onset of autoerotic and transitional phenomena. The former begins at birth and the latter between four and twelve months. Goodsitt (1983) elaborated on this, stating that:

> The transitional object both symbolizes the breast or mother and it is a real object which is not the breast. Winnicott stresses that the transitional object "not being the breast" (or mother) although real is important as the fact that it stands for the breast (or mother) (p. 92). . . .Winnicott is referring to the time in the infant's development when the infant has made significant progress in cognitively differentiating me from not me, but when experiential separation has not been achieved. (p. 52)

"Experiential separation" is not achieved until the completion of the separation-individuation phase (eighteen months), according to Mahler.

Swift and Stern's (1983) subtypes of anorexics can be matched here to Mahler's (1975) subphases of separation-individuation which will provide an understanding of object development and level of pathology. The "borderline" personality of the eating disorder would develop from traumas in the late symbiotic phase or the differentiation subphase. The "empty, understructured" would develop out of the late differentiation subphase to the early practicing subphase. The "emotionally conflicted, identity-

confused" personality would develop out of the late practicing subphase or early rapprochement subphase.

Christopher H. had moved into the differentiation subphase and was developing stranger anxiety. At six-and-a-half months, the trauma of the "frightening mother" laid the groundwork for the good object/bad object split which is seen as symbiolized in the binge/purge behavior.

A case presented by Sugarman and Kurash (1982) gives a clinical view of the good object/bad object split.

> Mary sought outpatient treatment in order to gain control over her "self-destructive behavior," the above-mentioned non-stop cycle of gorging and vomiting. . . .Mary's most frequent thoughts and images while binging involved her mother. "I think about her holding me, lovingly. Then suddenly, her grip tightens and I can't move. . .she used to tell me that I would get hurt if I let my body go. . .I start to feel stuffed and fat, fat like my mother. . . .I would rather kill myself than be like her, and that's when I throw up, when I become my mother." Her desperate desire to be loved by her mother led to her aggressive, vicious

> repudiation of her. Gorging became identified as an act of symbiotic reunion; vomiting as an act of separation from, if not annihilation of, mother. . . .Only at these times of filling or emptying her body could she develop a representation of important others. It was the interaction of the sensual and kinesthetic nature of the act of eating which prevented her from being alone. In this way she used her body as a transitional object--to maintain the illusion (representation) of being reunited with the needed other. (pp. 63, 65-66)

Mahler (1982) also stated that the "basic mood" of the individual probably is established during one of the subphases of the separation-individuation process. This is no more than "general emotional colorings," but could be seen as related to the predominance of affective disorders among the bulimic population. That is, both the traumas that result in the eating disorder and the affective disorder occur in the separation-individuation process, especially during the practicing subphase.

The theoretical discussion above helps to stress the need for a clear understanding of the developmental traumas influencing the bulimic behavior. Goodsitt

(1982) states, "The question must be asked, what is the value of developing an understanding of the traumas that result in the symptomatic behavior of bulimia? The value is in the treatment (p. 58)."

The therapist must be able to identify the stage of development of the bulimic patient in order to provide the tools for reworking these traumas. We may need to work to reduce experiences of overstimulation or fill the voids of undernurturance. We may need to make ourselves available as transitional objects ready to fill the deficits of the patient. Thomas (1984) states:

> It cannot be overemphasized that this attitude of needing to give freely to these clients, as a mother to her infant, to be attuned to and adaptive to their needs and anxieties, is not something to be acted out with them in general; rather it is to inform and enrich our interpretive understanding, and to allow us to bear the excess demands they will make on us. Addictive personalities are also afraid of taking too much if they take anything at all, and need to know the therapist can capably set limits. (p. 37)

Thomas clearly emphasizes the need of the therapist to have a clear understanding of the "needs" of the

client. Also, the therapist must be capable of providing the necessary structure for satisfying these needs.

Thompson and Gans (1985) also asked a relevant question: Do bulimics get well (p. 300)? In a review of the literature, they concluded that much of the slim literature on bulimia is anecdotal and qualitative. They note that:

> from the view of the outcome literature, it would be desirable if treatment studies could be designed with a long-term outcome portion in mind. It may take five or ten years, but by that time there will be an answer to the question "Do bulimics get well?" that is at least the equal of the answer we now have for anorexics. (p. 301)

Future empirical studies in the treatment of bulimia nervosa should include an assessment of psychodynamic therapy. This is especially true when the patient fits the diagnostic criteria for bulimia nervosa outlined in this paper. Specifically, a study concerning the use of psychodynamic therapy with bulimia nervosa having a clinical diagnosis of borderline personality would help to evaluate the most necessary use of psychodynamic therapy. The study would need to

include a two- to five-year treatment plan, which would require more resources than are available in most studies.

Another possible study would focus on the severity of the disorder based on duration of the bulimic behavior. This may be a more workable study in having groups of bulimia nervosa patients with symptomology occurring for ten years or more. One group would be treated with a psychodynamic emphasis, while the other focused more on behavioral techniques. This study would need to cover a year or more of treatment but has promising possibilities for showing the need for a psychodynamic emphasis in treating the more severely disturbed bulimics.

Summary

The purpose of this paper has been to review the literature to present a theoretical formulation of treating the bulimic emphasizing a dynamic component. There was a review of the importance of determining if there is a physiological base to the disorder before psychotherapy begins. For further reading in the area of physiological research, the reader is referred to Geiselman and Novin (1982a); Loro and Orleans, 1981; Mitchell and Pyle, 1982; Mitchell, Pyle and Eckert,

1981; Pope, Hudson, Jonas and Yurgelun-Todd, 1983; Rudnick, 1984; Wardle, 1980; Wilson, 1976; and Woodman, 1980.

The second step was to clarify the definition of bulimia used in this paper. This definition is consistent with the British terminology of bulimia nervosa (Fairburn, 1983; Russell, 1979). Even in distinguishing between the DSM III definition of bulimia and the definition of bulimia nervosa, there is still room for further clarification in the recognition that bulimia nervosa is a spectrum disorder. The individual pathology and unique childhood experiences prevent any uniform categorization of all bulimic patients, and thus any successful treatment program must be developed with the individual in mind, not just a general diagnosis.

Treatment outcome studies were reviewed where individual approaches did not prove as effective as an integrated approach to the treatment of bulimia nervosa. Two integrated approaches that were reviewed contained a psychodynamic component (Lazerson, 1984; Minuchin et al., 1978). These methodologically sound studies showed more consistently positive results than a pure behavioral approach set forth by Fairburn (1981). These findings suggest that the dynamic-oriented component of

treatment is crucial in the treatment of bulimia nervosa.

The emphasis on the dynamic component led to the final point of the paper, a discussion of the individual dynamics of bulimia. Case studies were used to provide clinical material for a better understanding of the application of the object relations view. Mahler's discussion of the separation-individuation phase was explored, as well as Winnicott's view of transitional phenomena. Bulimia nervosa is seen as having its roots in the separation-individuation phase of development.

Finally, it was emphasized that the apparent treatment of choice is an integrative approach which includes cognitive, behavioral, psychodynamic, group, and family therapy if appropriate. The importance of an individual psychodynamic component increases as the degree of underlying pathology increases.

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